COMMENTARY

The National Chlamydia Screening Programme and the NICE guidance on one-to-one interventions: remember the under-25s

Ian Simms, Teresa Battison, Mary Macintosh, Sarah Randall, Jan Clarke

In the government White Paper, *Choosing Health* the National Chlamydia Screening Programme (NCSP) is described as 'the cornerstone of the drive for better sexual health'.[1] The NCSP is delivered through interventions, which aim to control and prevent chlamydia, the most common bacterial sexually transmitted infection (STI) seen in England, through early detection and treatment of asymptomatic infection. This flexible approach includes one-to-one interviewing and innovative methods of opportunistic recruitment such as email access to postal kits in people <25 years of age.

Chlamydia infection rates are highest in sexually active men and women < 25 years of age, highlighting the importance of recognising those in this age range as a 'risk group'. The draft National Institute for Health and Clinical Excellence (NICE) guidelines omitted this group. The epidemiology of each STI, including HIV, is distinctly different, and it is important for practitioners to be able to distinguish between the different risk factors associated with these infections.

The recently issued NICE guidelines provide guidance and support to health care professionals who will deliver the NCSP but the guidelines appeared to focus exclusively on consultations in which patients are seeking care for an issue related to sexual health, such as requests for contraception or reporting of perceived STI risk. Health professionals reading the NICE guidelines should be aware that limiting the offer of screening only to such attendances would potentially disadvantage the NCSP.

As an opportunistic screening intervention, the NCSP is organised to capitalise on tunities to screen those aged <25 years when they attend healthcare and other non-clinical venues for any reason. Coordination at local level will target asymptomatic individuals who are sexually active, but who may not otherwise seek a test. The success of this approach partly depends on minimal practitioner involvement where time is limited. 'Instant' screening offers are particularly relevant for venues where NCSP test kits are distributed outside of formal clinical consultations. Clear information, and care and referral pathways enable access to appropriate interventions as necessary.

An expectation that all individuals will have extended face-to-face sexual health promotion interviews prior to screening may seriously impair uptake of chlamydia screening. Formal sexual health interventions may not always be undertaken at the point at which screening is offered. Instead, more structured interventions may be used once test results are available.

It is hoped the NICE guidance will help foster the development of sexual health services across a range of health care and non-healthcare settings. It is crucial that the guidelines are able to contribute to enhancing, not compromising, the performance of the NCSP.

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COMMENTARY

NICE guidance on one-to-one interventions to reduce sexually transmitted infections and under-18 conceptions: a view from general practice

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Health promotion is a cornerstone of general practice.[1] Issues including smoking, diet, alcohol and exercise are often raised with patients. However, given the restrictions of the 10 minute consultation, any intervention is brief. At best, it is reinforced with written information or referral. How will the new NICE recommendations on reducing STIs and teenage pregancies[2] influence those working in general practice?

ARE THE RECOMMENDATIONS APPROPRIATE TO GENERAL PRACTICE?

There are five recommendations relevant to doctors and nurses working in primary care. To be effective these need to apply to all practices, not just the select few providing gold-plated specialist sexual health services.

Recommendations 1 and 2 relate to counselling to reduce risky sexual behaviour. General practitioners (GPs) have little time to identify individuals at high risk and arrange sexual health counselling.

Even if they did, it is unlikely young people would attend. Many practices do provide brief opportunistic sexual health promotion. This might include providing contraception, condoms and leaflets. Some practices are also involved in the National Chlamydia Screening Programme (NCSP). Primary care-based health professionals might become more enthusiastic about sexual health counselling and condom promotion if they were aware that a more intensive intervention has been shown to prevent 9 STIs per 100 teenagers counselled.[1 3] However, very few practices will have personnel trained in sexual health counselling who can provide ''structured session(s) lasting 15–20 minutes''. Although such an intensive intervention is unrealistic in most general practices, this might be feasible by referral to youth services.

Recommendation 3 concerns partner notification. Because about half of young people referred to a genitourinary clinic fail to attend, it is vital that GPs and practice nurses who test for STIs undertake partner notification themselves. In one study, practice-based partner notification by trained nurses, with telephone follow-up by health advisers, was at least as effective as referral to a genitourinary medicine clinic for patients with chlamydia infection.[4] If the partner is also registered with the practice, providing testing and treatment is relatively simple. Usually this is not the case, so doctors and nurses working in general practice need to be made aware of new evidence on the effectiveness of patient-delivered partner therapy backed up by an information leaflet.[5] For example, the index patient could be prescribed a double dose of azithromycin 1 g immediately (to which most gonorrhoea is also sensitive) so that both partners are treated. Although GPs are usually reluctant to prescribe for someone they have not seen and who is not their patient, many will feel the benefits outweigh the risks.

Recommendation 4 relates to primary care trusts (PCTs). These are responsible for genitourinary medicine clinics and for community-based sexual and reproductive health clinics that offer contraception and some STI screening. Although there are exceptions,[6] funding is often inadequate, and few outreach clinics are computerised. The NCSP provides a few community health advisers who can help GPs with treatment and partner notification, but PCTs are unlikely to have resources for new posts.

Recommendation 5 concerns sexual health advice for vulnerable young people aged under 18, especially contraception and the benefits of long-acting reversible contraceptives. GPs and practice nurses do care for these young people when they attend. Many practices offer sexual health advice, condoms, contraception and STI testing to sexually active teenagers. However, this is a challenging client group who may not return for follow-up appointments. They are more likely to access Brook Young People's Clinics and other youth counselling and sexual health services where available. Better funding and support for these services would probably be highly cost-effective.

WILL THESE GUIDELINES AFFECT THE SEXUAL HEALTH WORK OF GPS?

Doctors and nurses working in general practices are drowning under a flood of guidelines. They receive recommendations from NICE on a wide range of topics every few weeks. Thus, publishing and distributing these new sexual health guidelines is unlikely to influence GPs who do not want to or cannot do more sexual health work. We believe there are three main messages for primary care:

1. Opportunistic sexual health promotion such as brief counselling can reduce the incidence of STIs.
2. Practice-based partner notification using patient-delivered therapy is effective.
3. Long-acting reversible contraceptives should be promoted in high-risk sexually active adolescent women.

The introduction of the Quality and Outcomes Framework for management of chronic diseases shows that financial incentives can change what GPs do. This powerful lever is currently under-represented in the sexual health field. To encourage implementation and ownership by those working in general practice, the new NICE guidelines need to be summarised on half a page of A4 and reinforced by practice-based educational interventions.[7]

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